ANALYTICAL AND BIBLIOGRAPHICAL NOTICES.

ART. XXV.—*St. George's Hospital Reports.* Edited by JOHN W. OGLE, M.D., F.R.C.P., and TIMOTHY HOLMES, F.R.C.S. Vol. VI., 1871-2. 8vo. pp. x. 433. London: J. & A. Churchill, 1873.

AFTER an interval, so long as to lead us to fear that the "St. George's Hospital Reports" was to be added to the dreary list of extinct medical serials, a sixth volume has at length appeared, and, whether as regards its general appearance or the scientific value of its contents, impresses us as being no whit inferior to any of its predecessors. According to custom we purpose inviting our readers' attention to the various articles contained in the volume, and shall first consider those papers which are of special interest to surgeons.

Three *Lettsomian Lectures* are contributed by H. LEE, Esq., the first being *On Syphilitic Urethral Discharges*, the second *On Prostatic Discharges*, and the third *On Non-syphilitic Urethral Discharges.*

Mr. Lee begins by referring to Hunter's celebrated experiment of which, upon the authority of the late Mr. Babington, Mr. L. assures us that Hunter was himself the subject—that experiment on the strength of which surgeons for so many years maintained the identity of gonorrhœa and syphilis; and then, briefly reviewing the more recent experiments and observations of Ricord, Wallace, Waller, Vidal, Rinecker, Rollet, Cullerier, and Morgan, avows his belief that there may be either a primary or a secondary syphilitic discharge from the urethra, contagious and capable of communicating true syphilis to a healthy subject, and of causing ulceration when designedly or accidentally inoculated upon one who is already syphilitic. We pause here for a moment to remark that Mr. Lee is obviously quite unacquainted with the Lectures on Venereal Diseases published some ten years since by our fellow-countryman Dr. W. A. Hammond, formerly of Baltimore, but now of New York; those of our readers who are familiar with the work to which we refer will not fail to see that many of the views lately advanced as novelties on the other side of the Atlantic were in great measure anticipated by Dr. Hammond. With regard to this question of contagious syphilitic urethral or vaginal discharges, we are prepared to believe that, as a *secondary* lesion, such a discharge exists, and is the medium of conveying syphilis, more frequently than is commonly supposed; but that such a discharge occurs as a form of *primary* syphilis without the coexistence of a chancre, we are not ready to acknowledge: in other words, we still hold to the doctrine that the initial lesion of acquired syphilis is invariably a chancre. It is not necessary, in the case of a muco-purulent urethral discharge accompanying a concealed chancre, to suppose, as Mr. Lee (page 13) appears to think that those who hold with us must suppose, that all the matter which flows from the meatus has been secreted by such chancre; for we know that in certain constitutions and under various circumstances large quantities of muco-pus may flow from the urethral, as from other mucous membranes, as the result of very diverse and sometimes quite trivial sources of irritation, of which the presence of a chancre in or even in proximity to the urethra may obviously be one. The simultaneous existence of a chancre and a discharge from the urethra, we therefore look upon as simply a coincidence; nor do we see any reason to believe that syphilis can be conveyed by urethral discharge alone, unless as already mentioned the occurrence of the discharge be itself a secondary symptom.

Mr. Lee's second and third lectures are interesting papers and may be read with advantage by all surgeons, but present few points which call for special comment; we will note only that urethral stricture is believed by the author to be not unfrequently of syphilitic origin, and then to require the use of mercury, and that the employment of caustics in cases of prostatic discharge (the "prostatorrhœa" of Prof. Gross) is discountenanced, and local applications of the solution of perchloride of iron, diluted in the proportion of from two to four fluidrachms to eight fluidounces of distilled water, regarded as equally efficient and as much more safe.

A Case of Osteomalacia is communicated by S. W. Moore, Esq., who acknowledges his indebtedness for notes of the patient's history to Mr. Richards, of the Hanwell Asylum. The patient whose case is here recorded was a woman nearly eighty years of age, who eleven years before her death had sustained a fracture of the leg; six years subsequent to this injury, fractures of both thighs; and again, during the last months of her life, a fracture of the left arm. For a long while she was bedridden, and her limbs presented in a marked degree the deformities which are known to characterize cases of mollities ossium. From Mr. Moore's account of the post-mortem appearances in this case we select the following description of the conditions observed by microscopic examination:—

> "A portion of the bone was subjected to Beale's carmine fluid. Sections, under the microscope, presented . . . . a matrix, probably granular, with irregular masses of bone-tissue proper, surrounded by a portion of decalcified tissue with a bold margin; the osteoblasts were large and irregular; in some cases faint outlines of the original Haversian systems could be traced, in others nothing but the isolated osteoblasts themselves. Subjected to a higher power the following was observed: the matrix in which the irregular masses of unaltered bone-tissue were situated had undergone a remarkable change, but one familiar to pathologists, viz., that of conversion to connective tissue; fibrillation could be distinctly seen in every part of this decalcified portion, in most cases following the curves of the remaining masses, but in parts distant from the recent changes irregularly distributed. Interspersed about this region were numberless corpuscles or cells, in which a distinct nucleus could be seen; these cells were considerably smaller than the osteoblasts. On the matrix, disposed in irregular masses, as described before, with a sharp well-defined outline, was situated that portion of the tissue undergoing change, and having in its centre unaltered bone; the borders of these were clear and translucent, with large osteoblasts scattered here and there, still occupying the position they formerly held in the original bone; they were, however, larger, with a distinct nucleus and the absence of canaliculi; the only trace of these latter was a jagged or projecting corner at one or two points of the corpuscle. Next in order, and within most of the masses, was the unaltered bone, in which lacunæ, canaliculi, and Haversian canals might easily be seen, apparently normal. Several Haversian spaces were also observed; sections deeply stained with carmine were only coloured in the unaltered parts."

The microscopic appearances in this case are shown by means of a lithographic plate containing several figures.

The next paper to which we shall refer is *On the Calculous Disease in Bombay and some other parts of India*, by H. V. Carter, M.D.

Dr. Carter shows not only that vesical calculus is a common disease in India (which, indeed, was known before), but that the composition of the majority of

Indian calculi differs from that usually noticed in England—uric acid and phosphatic calculi being much rarer, and oxalate of lime calculi much commoner in the former than in the latter country. The difference is attributed by Dr. Carter to the almost total exclusion of animal food from the diet of the Indian natives, to the diminished waste among them of the albuminous and gelatinous tissues, and to the excretion by the sudoriparous glands in the inhabitants of a warm climate of much organic matter which would otherwise be eliminated in the urine in the form of urates.

We turn next to a fourth instalment of Mr. PRESCOTT HEWETT'S *Contributions to the Surgery of the Head*, the title of the present communication being *On Congenital Encephalocele and Hydrencephalocele.* This is a very valuable paper, and is marked by the same practical tone which has characterized the author's other writings. The term *hydrencephalocele* has been ordinarily applied to any instance of brain-protrusion complicated by the existence of fluid in the sac, but Mr. Hewett is disposed thus to designate those cases only, in which the fluid is within a protruded portion of a ventricle.

"Thus viewed, an encephalocele is simply a protrusion of brain-substance, it may be of any part; and a hydrencephalocele a protrusion of brain-substance, involving a portion of one of the ventricles, filled with fluid. In both cases, fluid, either in the sac itself or enclosed in cysts, may be superadded to the brain-protrusion; in truth, a brain-protrusion, plus a watery tumour, with all its varieties."

These cases are to be distinguished, on the one hand, from those of *meningocele* (in which the sac contains fluid only, and in which neither brain-substance nor ventricles are involved), and, on the other hand, from cases in which multilocular cysts, originating in the neighbourhood of the ventricles, communicate with those cavities and ultimately protrude through the skull. In these cases the protrusion contains no brain-substance, and they cannot, therefore, with any propriety be called hydrencephaloceles. In the latter the brain-substance may always be recognized, even if much attenuated, at the neck of the tumour, though perhaps undistinguishable at other parts.

"In well-marked cases the symptoms and progress of an encephalocele differ in some respects from those of a hydrencephalocele. An encephalocele is of a round or oval shape; in size it seldom exceeds that of a small orange; its attachment is broad; the integuments covering it present little or no alteration. In the earlier periods, being for the greater part a watery bag, it has all the characteristics of such a tumour; but later on, as the fluid gradually disappears, the brain-matter fills the sac, and then the tumour becomes soft and doughy, and movements connected with the circulation and the respiration may become more or less evident. . . . Most authors dwell much upon this symptom as existing generally in congenital brain-tumour; but, in reality, it exists but in very few—in those only where there is little or no fluid. It is not present in encephalocele whilst there is a quantity of fluid in the sac; neither is it present in hydrencephalocele when the protruded brain is itself distended with fluid. . . . With this let a hydrencephalocele be now contrasted. In shape it is more or less pyriform, with a marked contraction at its attachment, sometimes a long and narrow stem; in size it is apt to become much larger than an encephalocele, oftentimes exceeding that of the child's head. The integuments, over-distended, are thinned, with an evident tendency to cracking and bursting; fluctuation, more or less distinct, exists about the hernia, and large and tortuous veins may be traced under the skin. . . . In a large hydrencephalocele the tumour is not affected either by the circulation or respiration; the state of the protruded parts—the distension and thinning of the brain-substance not unfrequently reduced to a mere membrane by the accumulation of fluid in the pouch-like prolongation of the ventricle—prevents this. . . . In endeavouring to establish a diagnosis between the various tumours of the cranial region, there are two points especially, in reference to congenital brain-protrusion, which ought never to be lost sight of—the congenital nature of the tumour, and the regions in which such a tumour is almost invariably found. A tumour, congenital and situated either in the occipital or fronto-nasal region, ought, in fact, to suggest at once the idea of brain-protrusion. A simple encephalocele may, it is true, make its appearance some short time after birth, and in other parts of the skull; but simple encephaloceles occur very rarely."

The *treatment* recommended by Mr. Hewett consists in compression—provided that the tumour be small and reducible—with paracentesis when the increase of the protrusion is rapid and due to the existence of fluid. Iodine injections are regarded with disfavour, as are attempts at excision, though the latter have proved successful in several recorded instances.

Following Mr. Hewett's elaborate paper is a communication from Mr. T. P. PICK, *On Cleft Palate.* Eleven cases are narrated, in all but two of which more or less successful results were obtained. Mr. Pick advises that the operation should not be attempted during very early childhood, and that when it is undertaken, the whole gap should, if possible, be closed at one sitting. For closure of the hard palate he employs sutures of silver wire, but in the case of the soft palate prefers plaited silk, which he considers preferable to the twisted silk ordinarily sold by instrument-makers. An abundant supply of fluid nutriment is looked upon as an essential part of the after-treatment.

Another paper by Mr. PICK is *On Partial Rupture of Arteries from External Violence.* In this communication are given the details of a very interesting case of femoral aneurism following an injury (probably rupture of the inner and middle coats of the artery) received five months previously. The aneurism, which was treated by digital compression on the proximal side, was distinctly circumscribed when the patient entered the hospital, but became diffused, by the giving way of the sac, six days subsequently. A fortnight later the limb became gangrenous, when amputation at the hip-joint was resorted to, the patient dying four hours afterwards. It is quite possible, as remarked by Mr. Pick, that a better result might have been obtained had the Hunterian operation been employed in the first place, but the great mistake in treatment seems to us to have been in that, when the rapid increase in the size of the tumour, in connection with other symptoms, showed the aneurism to have suddenly become diffuse, immediate recourse was not had either to amputation or to the "old operation," which, in the case of diffused femoral aneurism, is probably the best procedure, and which our readers will remember proved successful in cases recorded by Messrs. Birkett[1] and J. Cooper Forster.[2]

Mr. Pick's communications are succeeded by a short paper *On the Influence of Impaired Hearing upon the Voice and Speech,* by W. B. DALBY, Esq. The author refers to the well-known fact that young children who become totally deaf from the sequelæ of scarlet fever, or other causes, commonly lose also the power of articulation, and become reduced to the condition of deaf-mutes. To prevent this result, he strongly recommends that the system of education by "lip-reading" should be adopted in preference to that which relies upon the use of signs, so that the power of speech and natural tone of voice may be retained, or if lost regained, and the patient enabled to take part in ordinary conversation.

We shall next invite attention to a *Case of Femoral Aneurism,* by CLEMENT

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[1] Med.-Chir. Trans., vol. l. p. 431, and No. of this Journal for April, 1868, p. 489.

[2] Trans. Clin. Soc., vol. i. p. 36, and No. of this Journal for Oct. 1869, p. 475.

WALTER, Esq. Mr. Walter's patient was a middle-aged man of intemperate habits, and the aneurism, which was one of recent formation and very rapid growth, involved the left superficial femoral artery and extended to within a short distance of Poupart's ligament. For six weeks, pressure, both distal and proximal, and flexion were tried, but with no good result, and, at last, a ligature was applied to the external iliac artery, the patient dying four days later with symptoms of incipient gangrene. This case is evidently destined to find its way into surgical statistics as a fatal case of ligation; but who shall say how much the prospects of a successful operation were lessened by the six weeks' futile temporization to which the patient was previously submitted?

The next papers, which we may consider together, are a *Case of Cancer of the Upper Lip*, by EDGCOMBE VENNING, Esq., and a *Case of Cancer of the Upper Lip, following on Lupus*, by T. HOLMES, Esq.

Mr. Venning's patient was a man 37 years of age, who had had syphilis four years previously, and the lip-affection, which had begun as a fissure six months before he came under Mr. V.'s observation, was for nine months more looked upon as a syphilitic lesion and treated by the administration of mercury and iodide of potassium, the true nature of the case being thus unrecognized until the disease had existed more than a year, and until almost the whole lip had become involved. Excision was at last resorted to, but the disease recurred in a few months, and the patient died in about a year from delirium tremens. As regards the question of diagnosis we may be permitted to observe that although epithelioma or epithelial cancer of the upper lip is undoubtedly a very rare affection, it is hardly more so than would be a non-primary syphilitic ulcer of the same part, beginning as a fissure, and persisting and slowly increasing without the manifestation of any other symptom of syphilis, and without being in the slightest degree affected by long-continued anti-syphilitic treatment. The appearance of Mr. Venning's patient is shown in a rather too-highly coloured lithographic plate.

In Mr. Holmes's case no doubt was entertained as to the nature of the disease, and the case is chiefly interesting as an illustration of the fact that previous impairment of the nutrition of a part favours the development of epithelioma therein. Mr. Holmes refers to a case in which a tumour, supposed to be malignant, followed lupus in a patient under the care of Mr. Pollock, and adds that he has himself seen several examples of an analogous character.

The next paper is *On Contagious Ophthalmia*, and is contributed by R. BRUDENELL CARTER, Esq.

In this very interesting and practical paper, Mr. Carter adverts to the importance of not mistaking *improvement* for *recovery* in cases of contagious ophthalmia, the disease having a marked tendency to persist in a subacute form, ready to break out and spread upon the slightest provocation. He also explains how the disease is actually communicated through the atmosphere and not, as many suppose, exclusively through the common use of towels, etc.; a certain quantity of the contagious secretion flows through the lachrymal passages into the nose and is thence diffused by the expired air. The author lays great stress upon the propriety of having the sanitary inspection of schools, workhouses, etc., entrusted to skilled medical men only, and not as is too often done to persons who are totally unfitted for the purpose.

"Notwithstanding this," he adds, "it would be unjust to cast overmuch blame upon the inspectors, who, at the worst, commit no graver fault than to undertake to combine with their proper duties others for which they are unfit. At every principal railway station there is a person whose work it is to test the soundness of wheels by tapping them with a hammer. If a deaf man were selected for this office, and if an accident were occasioned by his failure to recognize the altered sound of a cracked wheel, we should not blame him so much as the superior who employed him. In like manner, the employment for sanitary purposes of functionaries whose sole qualification for them is the rashness engendered by utter ignorance, is the fault not of these functionaries, but of their official head. . . . . . . It would be idle to deny that there exists, in official and political circles, a widely-spread distaste to the employment of medical men for the performance of their proper functions. The reason is not far to seek. Political arrangements are made up of compromises, while science admits of none. . . . . When a doctor says, 'If you do this, such and such results will follow,' he is, if he speaks truly and from sufficient data, the mere mouthpiece of a physical law, and politicians have yet to learn, or at least to realize, that physical laws cannot be satisfied by half measures, and can neither be broken nor evaded with impunity."

We come next to a *Case of Aneurism of the Aorta and Innominate Artery, in which the Right Subclavian and Carotid were ligatured simultaneously, and on the failure of this operation Galvano-puncture was performed*, by T. Holmes, Esq. This case, which unfortunately resulted fatally, is already somewhat familiar to surgeons from having been referred to in Mr. Holmes's excellent course of lectures before the Royal College of Surgeons, published in the *Lancet* for 1872. It is, however, a case of so much interest that we are glad to find the full details of its history placed on record in a more permanent form than in the pages of a journal. The ligatures employed were of carbolized catgut, the wounds healing over the ligatures, and no trace of the latter being found at the post-mortem examination; the immediate cause of death appears to have been inflammation and sloughing of the aneurismal sac, if not as a consequence of, at least following very closely upon, the use of galvano-puncture. With regard to *diagnosis*, Mr. Holmes says:—

"After the most careful study which I have been able to give to the subject, I am still unable to point out any symptoms which would enable us to distinguish with confidence an innominate from an aortic aneurism. I am aware that diagnostic symptoms have been pointed out, but I have not found them trustworthy in practice, and I am led to believe that they have been deduced not so much from the observance of cases, as from *à priori* anatomical considerations, which in a region so complicated as this is cannot but be very liable to deceive. . . . . In a case in which the tumour is almost or altogether limited to the situation of the innominate artery, where the heart and its valves seem healthy, and where the difference between the pulsations of the carotid and subclavian (or their branches) on the right and left sides is well marked, it is fair to regard the aneurism as innominate, and to treat it accordingly."

As regards *treatment*, Mr. Holmes is disposed to hope much more from ligation of the carotid artery, than from that of the subclavian; the application of a ligature to the latter vessel in its third part (as a distal operation), he looks upon as being yet on its trial; tying the first part of the subclavian, he justly remarks, has so far been found more dangerous than letting the disease alone.

The *Report of Surgical Cases for* 1870–71, by J. W. Haward, Esq., and the *Report on the Department for Diseases of the Ear*, by W. B. Dalby, Esq., are both meritorious productions. The former contains numerous elaborate tables which will furnish a valuable mine to those who are fond of working in surgical statistics, while the latter gives an interesting account of the modes of treatment pursued at St. George's Hospital in cases of aural catarrh. J. A., Jr.

We shall now proceed to notice the remaining papers of the volume, and first a short article entitled *Remarks on the most common forms of Cutaneous Diseases in Children*, by Dr. R. J. Lee. The author combats the statement made by Vogel (*Diseases of Children*), that the same forms of cutaneous eruptions are met with in early as in adult life, and then proceeds to apply to the skin diseases of children the principles which Prof. Hardy has applied to cutaneous diseases in general.

Dr. Lee arranges the skin diseases of children under the four classes of Prof. Hardy, viz.: the dartrous, the occasional, the scrofulous, and the syphilitic; the class to which each disease belongs being defined by reference to the following points, namely: constitutional or hereditary tendency, local irritation, duration, liability to recurrence, and the conditions in which the skin remains after the disease has subsided.

In the succeeding paper Dr. GEO. CORDWENT narrates an extremely interesting case of *Sudden Death by entrance of Air into the Uterine Veins.* His patient was aged 28 years, and had proceeded favourably to full term; her expulsive pains became urgent, and at her request she was permitted, in the absence of her medical attendant, to remain standing; after a few severe pains, a fine, living, male child was expelled, and, falling to the floor, dragged with it the whole placenta. Almost immediately afterward a kind of gurgling sound was heard by the attendants, but whether that arose from rumbling in the bowels, they could not say. The patient remained about a minute standing as before, and holding on to the bed-post; she then cried out, "I can't see! I feel faint! lay me on the bed." Her request was obeyed, and she instantly died.

On examination twenty-four hours after death, the uterus externally presented the appearance attributable to recent child-birth, except that a portion of the wall of its fundus, to about the extent of a "five shilling piece," was slightly more puffy than the other portions; and on cutting into it air bubbles escaped. There had been no laceration of the placental surface; the uterine cavity contained only one small clot; its lining membrane was healthy. The coronary vein of the stomach was distended by air and contained only a fine thread of blood. The right side of the heart was slightly gorged, and when the auricle was punctured, air-bubbles escaped from its contained blood.

Dr. Cordwent believes that the entrance of air into the uterine veins is a very frequent cause of that frightful faintness and collapse which, after hasty placenta expulsions, is ordinarily attributed to loss of support to the organs of circulation. That air enters freely the cavity of the uterus after hasty delivery is known by the loud, sudden, almost startling flatulent explosion with which it is sometimes expelled. What more likely, asks Dr. Cordwent, than that portions of air should pass into the mouths of the veins at any moment when they may not be filled by outpouring blood, nor by clot, nor by application of placental surface? This deadly entrance of air, however, nature beautifully guards against by a peculiar construction of the veins, necessarily exposed after child-birth, by which they are smaller at their orifices than in their continuity within the wall of the uterus.

"In this construction of uterine veins, as in the phenomena of disease, we see nature often guarding life not by one barrier alone. So in this normal process we are now discussing, although the uterine veins are guarded, as I quote, by orifices smaller than their immediate tubes, the *primary* security against entrance of air is a due period of application of placental surface, and that due period I interpret to be, not only sufficient for it to act as a foreign body—foreign as the hand, but less offensive—but that it remain suitably supporting the uterine cavity until gradual contraction gently expels it; and expelled by this means, I have never known the placenta fail in the essential of bringing with it the whole of its membranes. By avoiding unnecessary and therefore offensive traction at the funis, we also avoid to a great extent the hour-glass contraction, and the great evil of abrupt exposure of an insufficiently prepared uterine surface."

The important lesson to be derived from the above Dr. Cordwent teaches in the following language:—

"I echo, with all the earnestness a strong conviction can inspire, the inculcation of those great men, the Hunters and Denman, that in ordinary labour the placenta should not be artificially removed in a shorter time than four hours."

Dr. ROBERT J. LEE contributes *Some Remarks on Inhalation*, which are followed by a short paper on *Indican in the Urine* from the pen of Dr. Francis Laking. In the opinion of the author of the latter article, the presence of indican in the urine is not, and its absence is, indicative of disease; and he is inclined to believe that there exists a relation between indican and carbolic acid which has not yet been defined. The natural odour of urine is said to depend upon the presence of a minute quantity of carbolic acid; the urine of patients absorbing carbolic acid certainly emits an increased odour, and gives a more marked indican reaction.

"The source of the indican in normal urine," Dr. Laking says, "I cannot pretend to say, but I think it must in some way be formed from the natural carbolic acid in the urine; for, when indigo is subjected to destructive distillation, ammonia and aniline are produced. Again, when carbolic acid is heated in a sealed tube with ammonia, aniline is formed; and, chemically, the composition of indigo and carbolic acid are not unlike. In that rough test for the presence of carbolic acid, by dipping a shaving of deal-wood into the suspected fluid, and then into hydrochloric acid, if carbolic acid be present, the chip becomes blue on being dried in the sun. May not that blue colour be indigo?"

The next article is *On the Employment of Quinine in the Treatment of Rheumatic Fever*. In this suggestive paper Dr. A. W. BARCLAY discusses the efficacy of the alkaline treatment of rheumatism, and while acknowledging as rational the endeavour to neutralize the acid which is so abundantly formed in rheumatic fever—one of the never-failing and evil accompaniments of the disease—he questions how far we succeed in attaining our object, since we find the salivary glands and the sweat glands pouring out acid abundantly in spite of the quantity of alkali taken into the system and circulating in the blood.

"In fact, as rheumatism is not merely acid but an acid-generating disease, so till the disease ceases the tendency will go on; and yet, after all, we are probably doing a real good, though we cannot by treatment succeed in arresting the acid formation. Notwithstanding the passage of an excess of alkali through the blood, and a highly-alkaline reaction of the urine, the disease will go on for some time unchecked, fresh joints become involved, and even cardiac inflammation may be developed. In fact, whatever may be said of the alkaline treatment of rheumatic fever, it cannot be called curative in the proper sense of the term. It may help to shorten the duration of the attack, it may serve to lessen the intensity of the inflammation, it may diminish pain, and it may not unfrequently ward off those more serious consequences which give to rheumatic fever its formidable character as a cause of heart-disease. All this it may do, and in my own opinion, and that of many others who have made the experiment, it does actually accomplish, but it does not cure. It does not put an end to the paroxysm, as bark puts an end to an attack of ague; it does not eradicate the disease, as iodide of potash will eradicate the traces of syphilis, commencing as soon as the system is sufficiently saturated by full doses of the remedy, and continuing till complete recovery takes place, with a progress unbroken as long as the remedy is used, retrograding as soon as it is left off."

Acid formation, while a very important, cannot be the essential, cause of rheumatism; still reason and experience point to the benefit to be derived from neutralizing that excess by the administration of alkali. To what extent this is to be done, and what are the dangers on the one hand, and the safe-guards on the other, are points which Dr. Barclay seeks to elucidate. He recognizes the "depression" which results from the long-continued use of alkalies, and discusses some of the means which have been tried to counteract it. (The evidence of the existence of "depression" he finds in the presence of a phosphatic deposit in an alkaline urine.) Stimulants avail to a certain extent, but have seemed to Dr. Barclay to tend of themselves to keep up the disease, to lengthen its duration, and even to re-excite it after it has subsided. Quinia is the remedy which in the author's hands has answered best, and under its use he has found the phosphatic deposit almost always to disappear.

In a short paper *On the Therapeutical Action of Sulphur*, Mr. CHARLES ROBERTS narrates a few experiments undertaken to ascertain if possible the precise therapeutic value of sulphur. The conclusions which he reached are that sulphur is not oxidized or volatilized at ordinary temperatures; when perfectly pure it is inert, and its well-known action as a parasiticide is to be attributed to the accidental presence of sulphurous and possibly sulphuric acids in the sulphur employed.

The practical application of this result can be readily inferred.

A very interesting paper *On Thrombosis in Cases in which the Arterial Walls and Viscera are Natural*, with the notes of eight such cases, is contributed by T. WHIPHAM, M.B. By limiting his observations to those cases of obstruction of cerebral arteries by fibrinous coagula in which other disease was absent, the author has presented a study of only those cases in which the thrombosis must have been dependent either upon the condition of the blood or of the arterial walls. In the latter case the cause is thought to be a local arteritis, the inflamed wall of the artery acting as a foreign body upon the blood and causing it to coagulate at the affected part. On the other hand, in persons whose powers are exhausted by dissipation or want, a tendency to coagulation is developed in the blood, and in most of these cases the obstruction which occurs is very extensive, and death very speedily results.

In those cases dependent upon a local inflammation of the arterial walls, the first symptom appears to be a convulsive seizure, or a slight attack resembling syncope, often unattended with actual loss of consciousness, but speedily followed by hemiplegia. Recovery from the paralysis to a great extent occurs as the circulation is restored, either by tunnelling of the clot, or by arterial anastomosis. Similar attacks, the result of like obstruction of the large vessels at the base of the brain, may occur at subsequent periods extending over several years, in fact so long as the circulation can be restored. Finally the plugging of some important vessel occurs after the circulation of other large arteries is interfered with, so diminishing the blood supply to the brain tissue that eventually softening takes place and death speedily follows.

The symptoms in those cases where the blood has a tendency to coagulate are somewhat different. The first attack is usually of the nature of syncope, and unattended by convulsive movements; death rapidly, in many cases almost suddenly, follows, though this may be in some measure due to the fact that the coagulation has occurred in large and important systems of vessels, such as the pulmonary, where any great interference with the circulation must of necessity be rapidly fatal. Another fact which characterizes most of these cases is the depressed or exhausted condition of the patients, which in some cases existed for a considerable time before death.

A very elaborate paper *Regarding certain Influences experienced by the Nervous System upon Bone* is contributed by JOHN W. OGLE, M.D. The author gathers facts to illustrate his inquiry from operations or experiments upon the lower animals, from certain accidents and injuries to man, and from cases in which known defects or perverted action of nerves or central nerve organs are attended by abnormal conditions of bone.

Illustrations are derived from various sources showing the influence exerted upon bony tissue by nerve and nervous centres: and of interference with its condition arising from modifications in nerve action, in some cases resulting in hypertrophy, and in others producing special conditions of the bone-tissue owing to changes of structure following changes in its vascularity, etc. Clinical experience points to the conclusion that any interference with the supply of blood to bone-tissue affects its nutrition; and the influence of nerves in regulating the blood supply is too well known to require the production here of the proof of it.

The *Report of Medical Cases admitted during the years* 1870–71, and the *Report of Maternity Department from* 1854 *to* 1871, *inclusive; with Observations on Revaccination during the Smallpox Epidemic of* 1871, conclude the volume, which, so far as the papers we have just noticed are concerned, we regret to say, fails to fully represent the rich stores of clinical experience which the above mentioned reports tell us annually accumulate within the medical wards of St. George's Hospital. I. M. H.

ART. XXVI.—*Experimental Researches on the Causes and Nature of Catarrhus Æstivus* (Hay Fever or Hay Asthma). By CHARLES H. BLACKLEY, M.R.C.S. Eng. 8vo. pp. ix., 202. London: Ballière, Tindall & Cox, 1873.

NUMEROUS treatises on this disease have appeared in England and on the Continent since it was first described by Dr. Bostock in 1819. More recently, thirty of these have been collected, and with additional observations combined in an essay by Dr. Phoebus, of Giessen. It would seem, therefore, that the literature of this singular affection is sufficiently full. Mr. Blackley's book, however, differs from its predecessors; his object is to give a record of his investigations into the causes and nature of the disease, besides which he gives us speculations growing out of his view of the facts obtained. The causes, as held by various writers, are enumerated and examined. Dr. Bostock believed that in his own case, the disease had no connection with hay, but was dependent upon the effects of heat and sunshine, especially after bodily exercise. Dr. Gordon attributed it to the aroma of grass flowers, especially to the *Anthoxanthum odoratum*, a sweet-scented vernal grass. Dr. Elliotson sides with Dr. Bostock, while others, with Dr. Phoebus, taking a wider view of the subject, attribute it to a peculiar idiosyncrasy combined with certain unknown causes acting during the heats of summer, and that with this predisposing state of things accesses or exacerbations may be produced by a variety of exciting causes, such as the odour of certain flowers or their pollen, smoke, dust, either vegetable, mineral, or that having certain chemical qualities.

Mr. Blackley starts with the idea that, although there may be other agents than pollen which may produce symptoms not unlike those of hay fever, they have not, as yet, been found; he therefore proposes to confine his attention to the phenomena of the disorder brought on by pollen. Nevertheless, he examines a few substances which have been suspected as causes; among them benzoic acid, coumarin, or the odoriferous principle found in some of the grasses and other plants and easily obtained from the tonka bean; odours of various kinds; ozone; dust, and the influence of light and heat.